# RADIOLOGY SERVICES

## ELIGIBLE PROVIDERS

In order to receive payment, all eligible servicing and billing provider's National Provider Identifiers (NPI) must be enrolled with South Dakota Medicaid. Servicing providers acting as a locum tenens provider must enroll in South Dakota Medicaid and be listed on the claim form. Please refer to the provider enrollment chart for additional details on enrollment eligibility and supporting documentation requirements.

South Dakota Medicaid has a streamlined enrollment process for eligible ordering, referring, and attending providers that may require no action on the part of the provider as submission of claims constitutes agreement to the South Dakota Medicaid Provider Agreement

Radiology services are covered when provided by the following enrolled providers:

- Physicians;
- Physician assistants;
- Dentist;
- Certified nurse practitioners;
- Chiropractors;
- Inpatient hospitals;
- Outpatient hospitals;
- FQHCs;
- RHCs;
- IHS/Tribal 638 Facilities;
- Podiatrists; and
- Radiology Units/Independent Diagnostic Testing Facility.

## ELIGIBLE RECIPIENTS

Providers are responsible for checking a recipient's Medicaid ID card and verifying eligibility before providing services. Eligibility can be verified using South Dakota Medicaid's online portal.
The following recipients are eligible for medically necessary services covered in accordance with the limitations described in this chapter:

| Coverage Type | Coverage Limitations |
|---|---|
| Medicaid/CHIP Full Coverage | Medically necessary services covered in accordance with the limitations described in this chapter. |
| Qualified Medicare Beneficiary – Coverage Limited (73) | Coverage restricted to co-payments and deductibles on Medicare A and B covered services. |

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| Unborn Children Prenatal Care Program (79) | Coverage restricted to pregnancy related services only including medical issues that can harm the life of the mother or baby. |
| Medicaid Renal Coverage up to $5,000 (80) | Coverage restricted to outpatient dialysis, home dialysis, including supplies, equipment, and special water softeners, hospitalization related to renal failure, prescription drugs necessary for dialysis or transplants not covered by other sources and non-emergency medical travel reimbursement to renal failure related appointments. |

Refer to the Recipient Eligibility manual for additional information regarding eligibility including information regarding limited coverage aid categories.

## COVERED SERVICES AND LIMITS

**General Coverage Principles**

Providers should refer to the General Coverage Principles manual for basic coverage requirements all services must meet. These coverage requirements include:

- The provider must be properly enrolled;
- Services must be medically necessary;
- The recipient must be eligible; and
- If applicable, the service must be prior authorized.

The manual also includes non-discrimination requirements providers must abide by.

**Radiology Coverage**

South Dakota Medicaid covers medically necessary radiology services which are directly related to the recipient's symptoms or diagnosis. Services must be provided by or under the direction of a recipient's treating physician or other licensed practitioner within the scope of practice as defined by state law. To be covered, the physician or practitioner must furnish a consultation or treat a recipient for a specific medical problem, the service must be expected to yield results that will be used by the treating physician or practitioner in screening, diagnosis, or management of a recipient's specific health problem, and must meet any applicable coverage criteria.

**Professional Component**

The professional component of a radiology procedure includes the professional services of the physician or other licensed practitioner and the following:

- Examination of member when indicated;
- Performance or supervision of the procedure;
- Interpretation; and
- Written report of the examination.

**Technical Component**
The technical component of a radiology procedure code includes the personnel and materials, including:

- Contrast media and drugs;
- Film or xerography;
- Space;
- Equipment; and
- Other facilities.

**CT Scans**
South Dakota Medicaid covers diagnostic examination of the head (head scan) and other parts of the body (body scans) performed by computerized tomography (CT) scanners, subject to the following restrictions:

- The scan should be reasonable and necessary for the individual recipient;
- The medical and scientific literature and opinion support the effective use of a scan for the condition;
- The use of a CT scan must be medically appropriate, considering the recipient's symptoms and preliminary diagnosis; and
- The equipment used to perform the CT scan must be certified by the Food and Drug Administration (FDA).

Low Dose CT Scan (LDCT)
Recipients who meet the following criteria qualify for annual lung cancer screening using LDCT scan

- Age 50-80;
- Have no signs or symptoms of lung cancer;
- Have a 20 pack year or greater smoking history (One pack year = smoking one pack per day for one year; 1 pack = 20 cigarettes);
- Currently smoke or have quit smoking in the past 15 years; and
- The patient does not have a health problem that substantially limits life expectancy of the ability or willingness to have curative lung surgery.

The service must be billed under HCPC 71271.

**PET Scans**
All claims for reimbursement of Positron Emission Tomography (PET) scans must include an appropriate International Classification of Diseases (ICD) diagnosis code. HCPCS A9597 and A9598 may not be reported if a procedure code that describes the service has been established.

**Upper Gastrointestinal Studies**
South Dakota Medicaid covers upper gastrointestinal (GI) studies when performed for detection and evaluation of diseases of the esophagus, stomach, and duodenum.

**Mammography**
South Dakota Medicaid covers medically necessary mammography services. All facilities (hospital, outpatient department, clinic, radiology practice, mobile unit, physician's office, or other facility) providing diagnostic and screening mammography services are required to have FDA certification under the Mammography Quality Standards Act (MQSA). No facility may conduct an examination or procedure involving mammography unless the facility has obtained an MQSA certificate.

**Dental Services**
Please refer to the Children and Adult Dental Provider Manuals and the Dental Services fee schedules for information regarding covered services.

**Chiropractic Services**
Please refer to the Chiropractic Services manual and the Chiropractic Services fee schedule for information regarding covered services.

**Podiatric Services**
Please refer to the Podiatric Services manual and the Podiatric Services fee schedule for information regarding covered services.

**FQHC/RHC Services**
Please refer to the FQHC and RHC Services manual for additional information regarding covered services.

**IHS and Tribal 638 Facilities**
Please refer to the IHS and Tribal 638 Facilities manual for additional information regarding covered services.

## NON-COVERED SERVICES

**General Non-Covered Services**
Providers should refer to ARSD 67:16:01:08 or the General Coverage Principles manual for a general list of services that are not covered by South Dakota Medicaid.

**Non-Covered Radiology Services**
South Dakota Medicaid does not cover the following services:

- Tests that are performed in the absence of signs, symptoms, complaints, or personal history of disease or injury; and
- Portable x-ray transportation or set-up of portable x-ray or EKG equipment (HCPCS are not covered: R0070, R0075, R0076 or Q0092).

## DOCUMENTATION REQUIREMENTS

**General Requirements**
Providers must keep legible medical and financial records that fully justify and disclose the extent of services provided and billed to South Dakota Medicaid. These records must be retained for at least 6 years after the last date a claim was paid or denied. Please refer to the Documentation and Record Keeping manual for additional requirements.

## REIMBURSEMENT AND CLAIM INSTRUCTIONS

**Timely Filing**
South Dakota Medicaid must receive a provider's completed claim form within 6 months following the month the service was provided. Requests for reconsiderations will only be considered if they are received within the timely filing period or within 3 months of the date a claim was denied. The time limit may be waived or extended by South Dakota Medicaid in certain circumstances. Providers should refer to the General Claim Guidance manual for additional information.

**Third-Party Liability**
Medicaid recipients may have one or more additional source of coverage for health services. South Dakota Medicaid is generally the payer of last resort. Providers must pursue the availability of third-party payment sources and should use the Medicare Crossover or Third-Party Liability billing instructions when applicable. Providers should refer to the General Claim Guidance manual for additional information.

**Reimbursement**
A claim must be submitted at the provider's usual and customary charge. Payment is limited to the lesser of the provider's usual and customary charge or the payment amount established on the department's fee schedule website.

CPT codes with TC modifier appended are reimbursed at the lesser of the provider's usual and customary charge or 60% of the established fee. CPT codes with the 26 modifier are reimbursed at the lesser of the provider's usual and customary charge or 40% of the established fee.

FQHC/RHC
Please refer to the FQHC and RHC Services manual for reimbursement information including information about when a service is a billable encounter and reimbursement for the technical component .

IHS and Tribal 638 Facilities
Please refer to the IHS and Tribal 638 Facilities manual for reimbursement information including information about when a services is a reimbursable encounter.

**Claim Instructions**
Professional services should be billed using the CMS 1500 claim form or via an 837P electronic transaction. Facility services should be billed using a UB-04 claim form or an 837I electronic

transaction. Detailed claim instructions are available on our website. Providers must follow guidance in the CPT codebook for reporting radiology procedures.

Modifiers

To identify a charge for the technical component, append the TC modifier to the procedure code. If a procedure code is defined as the technical component only (of a service), do not use the TC modifier. When billing a radiology service where the technical component of a procedure code was billed by a facility, a 26 modifier must be appended to the procedure code for the professional component of the service to be paid. Failure to append an appropriate modifier is cause for payment denial or recoupment.

## REFERENCES

- Administrative Rule of South Dakota (ARSD)
- South Dakota Medicaid State Plan
- Code of Federal Regulations

## QUICK ANSWERS

1. **Can a provider bill for the contrast separately?**

   Providers may only bill for the contrast separately if it is not included in the procedure code description.